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MEDICAID AND AFDC FRAUD AND ABUSE CONTROL AND RESTITUTION EFFORTS BY STATES AND LOCALITIES

OPTIONS FOR REDUCING FRAUD AND ABUSE IN THE MEDICAID PROGRAM

April 1977

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU

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Prepared under SRS Contract No. SRS-500-75-0004

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April 1977

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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ACKNOWLEDGMENT

The authors wish to acknowledge the contribution of Mr. David Arnaudo of OPRE/SRS for his direction and assistance throughout the project.

General Research Corporation also wishes to acknowledge the valuable contribution which has been made to this study by the staff of our subcontractor, SysteMetrics. Many of the concepts presented in this paper are based on data collected by SysteMetrics staff and ideas they have contributed.

Finally, this paper would not be possible without the generous assistance which was provided by the many states involved. General Research Corporation wishes to thank these states and particularly the many state and local employees who graciously shared time and knowledge.

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I. INTRODUCTION

The purpose of this paper is to present concepts which we believe have the most merit with respect to enhancing prevention, detection, investigation, and control of fraud in the Medicaid program. The concepts are presented as a framework of options available to the Federal and state governments. Although some of the concepts presented clearly have implications for amending the Social Security Act and state structures as well as for modifying Federal and state regulations and although we cite specific sections of the Act and Federal regulations, we do not suggest specific language changes in this paper. We believe such specific recommendations, particularly concerning the language of Federal regulations, must await more basic decisions concerning welfare reform and national health insurance in general and adoption of individual concepts for control of fraud and abuse in specific. The discussion in this paper is primarily related to the problems of Medicaid provider fraud and abuse, although limited discussion is also directed to the issues of recipient fraud and abuse and Medicaid agency employee fraud. All of the concepts presented are based on an eighteen month study by General Research Corporation of fraud and abuse control activities in the Medicaid and Aid to Families with Dependent Children program.

1. Background of the Study

This paper is one of a number of reports resulting from General Research Corporation's study "Medicaid and AFDC Fraud and Abuse Control and Restitution Efforts by States and Localities" conducted under contract to the Office of Planning, Analysis and Evaluation of SRS. The primary objectives of the study are to identify the "best practices" currently being used by states to control fraud and abuse in the Medicaid and AFDC programs, to provide an analysis of the options available which would significantly improve fraud and abuse control, and to enhance the currently available data on the status of state activities in these areas.

For purposes of identifying best practices and program options, GRC staff and the staff of our subcontractor, SysteMetrics, visited nine state Medicaid programs and nine state AFDC programs in the summer of 1976. Working with both SRS headquarters and regional office staff, 18 programs were identified as being suitable for site visiting at that time and as appearing to be most active in the fraud control area.

The states involved included:

AFDC*	Medicaid
Maryland	California
Massachusetts	Maryland
Michigan	Massachusetts
Minnesota	Michigan
New Jersey	New Jersey
Ohio	Ohio
Pennsylvania	Oklahoma
Washington	Pennsylvania
Wisconsin	Washington

A detailed review of program operations was conducted in each state program. From the initial stages of the study, GRC has operated with the philosophy that fraud and abuse control is inextricably bound to the overall management and operation of a program and, therefore, review of the functioning of the entire program is required to understand fraud and abuse control. State programs studied are reported in the GRC "Best Practices" Case Studies series. Each of the reports in this series presents the documentation of a selected state program and its procedures. A separate section of each report assesses the best or exemplary practices demonstrated by that state program.

The review of state operations involved in the site visits also served as the basis for identifying the ideas or options described in this report. Therefore, the basic documentation of state activities on which this report is based can be found in the Case Study series. When appropriate, citations are made in this paper concerning discussions in the case studies which will provide the reader additional information.

Finally, although fraud and abuse in Medicaid and AFDC are highly related, the purposes of reporting are best accomplished through separate options reports. Therefore, options relating to control of AFDC fraud are contained in a companion paper.

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*California and New York were excluded from consideration for the AFDC sample because key aspects of their fraud control activities had previously been presented in the DHEW "How They Do It" series.

2. Organization and Objectives

Given the fact that comprehensive discussions of welfare reform are currently in progress, this paper has been prepared using as comprehensive an approach as possible so as to provide DHEW and state policymakers with a wide breadth of ideas and options suitable for discussion purposes. The objective of this paper is to raise policy considerations related to Medicaid fraud and abuse control which relate directly to existing problems and which highlight fraud-related issues which must be considered in any welfare reform package or national health insurance proposal.

Each option discussed in this paper is presented in terms of GRC's analysis of the most appropriate method for its implementation. Options generally fall into four categories:

- legislative options requiring Congressional authorization to implement;
- regulatory options requiring DHEW regulatory amendments or new regulations;
- policy options involving actions to be taken by DHEW not requiring regulatory change; and
- programmatic options involving those actions to be taken most appropriately by state agencies in terms of their policy or administrative procedures.

It is GRC's intent that each option is presented with sufficient discussion so that the reader may understand the problem addressed by the option and the value of the action. Of course, our analysis of the implementation action required may become obsolete in the context of a radically modified program if the Medicaid program undergoes major modifications.

For presentation and readability purposes, the options are organized by subject heading. This method was used to present a detailed discussion of the problems involved in each subject area and then to present a discussion of a range of options available and the implications and interaction of the options in each category. Therefore, within each subject area category the reader will find various related problems discussed and various types of options suggested.

3. Overview of Fraud and Abuse Control Issues

Fraud is a word with a narrow legal definition generally involving gaining something of value through willful misrepresentation. Criminal penalties are provided in law for fraud. In relation to Medicaid, fraud can take the form of kickback schemes, shorting of prescriptions, false billings, etc, by providers or improper use of a Medicaid card by a recipient (such as allowing another person to use the card for some consideration). Fraud can also be committed by a recipient by withholding correct information or supplying false information at the time of his application for Medicaid or later if his eligibility status changes. However, since eligibility for Medicaid is highly dependent on eligibility for AFDC, this paper does not consider eligibility fraud. Instead the reader is referred to the companion GRC options paper for AFDC fraud control. Fraud can also be committed by Medicaid agency personnel although we do not believe this is a major problem in the program.

Medicaid abuse is less easy to define. Abuse involves conduct in violation of program regulations or conduct involving questionable ethical or medical judgments (including such judgments made by recipients) for which criminal penalties are not available. Thus, recipient abuse can take the forms of "doctor shopping" or gross overutilization of services. Examples of Provider abuse include provision of unneeded services, "ping-pong" referrals between providers, provision of services in a substandard or nonprofessional manner, and "prescription splitting" (filling a prescription for only a portion of the authorized amount—and billing for only that portion—so the recipient must return often to have the prescription refilled and so the pharmasict receives additional fees.*

Throughout this report we assume that states have established firm regulations relating to Medicaid abuse. Such regulations should define in so far as it is possible to do so before the fact what actions constitute abuse. Such a regulation in relation to pharmacists, for example, would require that prescriptions which are expected to be used over an extended period should be filled in quantities which would last a minimum of a month unless the physician specifies a smaller dispensing unit for a valid

*Note that if a prescription splitting pharmacist billed for the entire amount of a "split" prescription, fraud would be involved, not abuse.

medical reason. Thus a pharmacist which ignored this regulation would clearly be guilty of program abuse and could be sanctioned by the Agency. In the absence of a clear regulation, the Agency could do little more than counsel the pharmacist; enforcement of its position would be difficult. Thus clearly defined regulations concerning abuse are of the first importance. We recognize that this paper's assumption that such regulations exist in the states is largely erroneous. It would serve little purpose, however, to have to preface every discussion of abuse in different areas with a repetitive discussion of the importance of tight regulations. Therefore we assume both the Federal government and the States are aware of the necessity for such regulations defining abuse and are developing and implementing them as the sine qua non of abuse control. We also assume that these regulations and adequate explanations of them are made available to recipients and providers affected by them. Effective abuse control is particularly hampered by the claim of "I did not know about the regulation."

Based on our study of fraud and abuse control problems, it is our conclusion and recommendation that the greatest emphasis be placed on preventing fraud and abuse and detecting as soon as possible fraud and abuse cases which are not prevented. It is striking how many of the high dollar, high visibility cases involve fraud schemes which have continued undetected for a long period. This paper is written from the philosophic base that the goal of fraud and abuse control efforts must be to save money and protect the program's integrity. Actions in the area of investigation and administrative or prosecutorial outcomes are secondary and serve primarily to penalize those few flagrant offenders, although they also serve as deterrents to those who might consider attempting fraud.

This philosophy is based on three very real considerations. First, fraud prevention and detection methods are generally inextricably bound to the quality of management of the Medicaid program and investment in these areas will have payoffs not only in fraud control but also in other areas. Secondly, complete recovery of misspent funds appears to be an unrealistic and unachievable goal, so that no matter how good the program, it will never recover major percentage of its losses to fraud and abuse. Therefore, the program must attempt to protect itself through prevention methods and detection systems which limit the probability of fraud and abuse

existing for any extensive length of time. To summarize, although investigation and prosecution are discussed in this report, the authors' intended emphasis is on options aimed at prevention and early detection of fraud and abuse.

A large number of ideas presented in this paper are dependent on an activist posture on the part of DHEW with respect to fraud control. An activist posture includes the availability of resources and staff to implement new policy and to assist the states. DHEW must provide information and skills to the states to identify problems and resolve them. Problems will not be resolved in a timely manner through merely monitoring state programs, collecting data, and enforcing regulations. DHEW must take a problem solving approach to assisting the states in improving the programs.

4. Coordination within State Medicaid Agencies

Just as it is crucial that the states work from well drawn regulations defining abuse, it is equally important that the state agencies are well organized and are coordinated in their internal activities. No state program of fraud and abuse control will be effective unless the components responsible for prevention, detection, investigation, and sanctions work together closely and do not duplicate each other's functions. Unfortunately in many states there seem to be inadequate working relationships between the units within the state agencies. Given such situations, it is hardly surprising that relationships with outside agencies, such as Attorneys' General Offices, are even more subject to breakdown. Poor communication and coordination both internally and externally result in inefficiency in performing the total fraud and abuse control function even if each unit uses the most efficient techniques to do its own job. We discuss this problem in the Introduction rather than with each aspect of prevention, detection, etc., because the resolution of this problem is of the highest importance for administration of all aspects of an effective fraud and abuse control program. It is basic to effective implementation of all options discussed later in this paper.

5. Third Party Liability

This options paper does not contain a discussion of Medicaid agency recovery of expenditures in cases with third party liability. We do not consider this area to involve either fraud or abuse, although techniques for efficient recovery of this party liability are similar to some techniques used in efficient fraud and abuse control. Third party liability is discussed in some of the GRC Medicaid "Best Practices" reports and the reader interested in this non-fraud-or-abuse area is referred to these reports.

II. PREVENTION OF PROVIDER FRAUD AND ABUSE

A good fraud control system must include well functioning integrated systems for the conduct of each function—prevention, detection, investigation, and sanctions. Prevention is an integral part of the overall system. It must be viewed as such for several reasons:

- In general, prevention activities require a smaller investment than the resources required to support investigations once fraud or abuse has occurred.
- Prevention activities can eliminate some types of fraud and abuse so that investigations resources can be applied to the fraud and abuse of other types which are more difficult to prevent.
- A good prevention system can serve to minimize the misspent program dollars which not only are expensive to recover, but which also are rarely recovered at the 100% level.

Despite their obvious importance, preventive options have been given minimal attention in Medicaid fraud control except in states with the MMIS. Instead, in many states, prevention has been handled in a haphazard manner, using techniques which have been revised or updated since the earliest years of the program.

This chapter presents options for control of provider fraud and abuse. Options for control of recipient and employee fraud and abuse are discussed in later chapters.

Prevention activities in relation to providers fall into two general categories: (1) actions which discourage providers from attempting to defraud or to abuse the program and (2) actions which prevent the payment of spurious or suspicious claims. The following subsections discuss the various program activities which should be implemented or strengthened to assure a sound prevention program.

1. Actions to Discourage Provider Fraud or Abuse

A. Provider Enrollment

Provider enrollment for participation in the program is an overlooked function which is usually handled in a quite routine manner. Such a procedure seems to follow from the regulatory requirement* that recipients

*45 CFR 249.20

can receive services from any provider qualified to provide services in the state. This requirement, however, should not prevent states from using the provider enrollment process to prevent or minimize certain types of fraud or abuse, as is done in Massachusetts. Two elements are critical: (1) examination of providers' qualifications and (2) education and orientation programs for new providers. Strict monitoring of the early months of a provider's participation is also important.

Qualifications Examination. The program should carefully check licensing status and specialty to determine what services each provider is certified to perform. This is a matter of good liaison with the state's licensing and/or accreditation authorities. The program should also stipulate that it will not pay for services a provider is not qualified to perform based on the prevailing standards. Most states take these measures (although perhaps perfunctorily), but states must also take steps to ensure that licensing/accreditation authorities regularly provide updated information on the changes of status of providers.

Another type of screening is also appropriate during the applications review process. If a means exists (as recommended later in this report), a state agency should check with other states to determine whether a provider applying for admission to the program has been involved in Medicaid fraud or abuse in another jurisdiction. Providers which have been so involved should either not be admitted to the program or monitored closely, depending on the circumstances.

Provider Education. Once a provider has been accepted into the program, provider education and orientation should receive emphasis. Such education has long been an element of most state programs, but in general is not viewed or conducted as a priority activity with implications for fraud control. Instead, formal provider education is usually limited to "education" in terms of the correct methods for filling out and filing claims.

Such limited orientation is inadequate. Provider education units should also provide information concerning program policies. In addition to simply receiving policy manuals, providers and their employees must have the opportunity to ask questions and discuss program policy, policy interpretations by the agency, and agency expectations concerning compliance. Discussion of this type would not only inform providers but would also warn them that the

agency is concerned about particular issues and is prepared to enforce policy.

Implementation of expanded provider education involving policy as well as billing forms touches the functions of several units typically found in a Medicaid agency. These units include the policy and interpretation unit, the surveillance and utilization control unit, and the claims processing unit. Probably the ideal organizational response to this complex environment is establishment of a single provider education and relations unit responsible for all provider education and orientation, but clearly dependent on the other cognizant units for the information it transmits. This unit would be responsible for planning and organizing provider seminars and training activities. It should not be a step-child within some other unit within the agency.

Provider education or public relations could be expanded to include other activities in addition to formal training. In Ohio, one member of Surveillance and Utilization Review (S/UR) staff has made a concerted personal effort to write articles for professional publications on the functions of S/UR as an attempt to alert and warn providers that the agency is regularly reviewing claims for problem cases. This type of publicity, as distinguished from newspaper publicity on major investigations and prosecutions, should be institutionalized as a regular function of the provider education unit. A related activity is making presentations to provider meetings and groups. The provider education/relations unit would not necessarily be responsible for all writing and speaking, but could generate and handle requests and scheduling, as well as identify appropriate authors and speakers within the agency. The key point is to provide a focus for an ongoing program of provider education. A unit responsible for planning agency initiatives in the area of informing providers as to program policy and agency activities to enforce that policy would provide that focus.

B. Claims Reviews for New Providers

Another area related to provider education and maintenance of good relations with provider organizations is special monitoring of the claims of new providers. Although this monitoring can be thought of as an action which prevents payment of spurious or suspicious claims (discussed in the next section of this chapter), the authors see new provider claims monitoring more as an adjunct to provider education and orientation than as means of preventing payment of specific fraudulent claims.

Monitoring of new providers is an important option. It ensures that a new provider understands and uses proper billing procedures; it also allows health care reviewers to examine his/her pattern of practice and identify an aberration promptly. At this initial stage of participation, the provider should be more amenable to warnings or comments from the program since they can be offered in the spirit of assistance and mutual benefit. The procedure also allows the program to subtly warn the provider that it does review claims. Since there should not be a large number of new providers entering the program at any one time this should not substantially increase the agency's workload. If necessary, initial review could be limited to certain categories of problem providers. This is an easy and simple way of solving billing errors or program abuses before they become a major problem involving large amounts of misspent funds and before the provider has been involved long enough to become defensive about his actions. The option has been adopted in Westchester County, New York, with beneficial results.

C. Agency Access to Provider Records

Another technique which would have value in discouraging provider fraud and which would also be very helpful in investigating suspected fraud involves Agency use of provider agreements which require that a provider makes all his records (including records concerning non-Medicaid patients and activities) available to the Medicaid agency on request as a condition of participating in the program. The agreement should include access to patient records under the control of a provider as well as nonpatient records. It should be noted that such an Agency-provider agreement goes beyond the scope of the agreement contemplated in current regulations (45 CFR 250.21) which requires only access to Medicaid-related records. It is important that access be granted to all records since it may be possible to prove fraud only if Medicaid records are used in conjunction with or in comparison to other records. Legislation may be needed to protect providers from suits covering breach of confidentiality records in order to implement this proposal.

If possible, Medicaid agencies should also attempt to gain access to tax records and inform providers that such records are examined in appropriate cases, such as those involving suspected kickbacks. The knowledge that the agency may examine tax records may be sufficient to deter provider participation in kickback schemes.

D. Relationships with Provider Organizations

Provider organizations may be a source of assistance in fraud and abuse control. Providers, their organizations, and the Medicaid program share a major goal—provision of accessible, quality care within accepted standards of medical practice. Unfortunately, however, too often the mutual goal is forgotten by both parties as individual issues create conflict. A generalized adversary relationship may develop. The publicity around fraud in the Medicaid program is an example of such an issue since some providers may feel that the Medicaid program damages the reputation of all providers by commenting on or publicizing provider fraud cases.

There are two basic reasons for concern for the quality of this relationship. The first is the program's need to assure adequate participation by providers and accessible services for clients. Lacking positive relationships with provider groups, particularly in states where adequacy of reimbursement levels is a continual problem, some states are fearful of wholesale dropouts if fraud and abuse is actively pursued. This need not necessarily be a problem if support from major provider organizations exists for strict fraud control. Such support should be based on the providers' understanding that program integrity works in their best interests. The Medicaid program should work with provider organizations to gain their understanding and cooperation. In addition, the agency should be aware of legitimate concerns of providers. For example, in publicizing fraud the agency should emphasize that fraud is a problem with only a few providers so that the reputations of honest providers are not damaged.

A second major reason for having the support of provider organizations is to gain their assistance in dealing with problem providers. There are certain types of problems, particularly with respect to program abuse and poor quality services, which are best handled or can only be handled by the provider's professional organization. For example, overutilization or inadequate quality of particular services or tests as supplied by certain providers may not be an abuse which can be easily addressed within program procedures or regulation. Such abuses can be referred to the professional peer group such as the medical society for review and action, if the agency has the necessary relationships with provider organizations. The program

must have a relationship with professional groups such that they will actually review the case and take action if warranted. In many instances, providers may be more sensitive to this peer pressure than most forms of penalties or sanctions by the agency.

While many Medicaid agencies have expressed suspicion, and in some instances dissatisfaction with peer review groups, other states have developed satisfactory working relationships with peer review groups. One example is in North Carolina where the North Carolina Medical Peer Review Foundation has been a subcontractor to the state responsible for all utilization review activities.

Good relationships with professional organizations should also have a "spin-off" effect in terms of the willingness of providers to consult with the program on the development of policy, medical review, etc. Good relationships will also increase the willingness of those consulted to confront peers on behalf of the program.

To summarize, in the din of publicity around fraud in the Medicaid program, both the states and the Federal government must be aware of not only the dependency of the program on providers but also the positive value of open communication and good working relationships between providers and the program.

E. Control of Factoring

There is great concern for the issue of providers "factoring" claims through collection agencies. Factoring may have the effect of stimulating utilization, increasing submission of false claims, and introducing organized crime into the Medicaid fraud problem.

Factoring is addressed in this prevention section of the report, because factoring and the problems it creates can be prevented. Indeed prevention is the only effective way of dealing with factoring and related problems. Prevention, in one sense, is simple. States which pay the majority of claims in a reasonably short period of time (approximately 30 days) have not experienced problems with factoring, because there is no incentive to providers to factor claims to receive faster payment.

Factoring occurs because providers may experience cash flow problems if claims are not paid rapidly and because slow claims payment is usually directly related to poor claims payment procedures which make dealing with

the Medicaid agency difficult. In such situations, claims may be returned unpaid with no intelligible explanation, the provider may not be able to find out when or what claims will be paid, etc. The problem faced by the provider can be easily understood in terms of the provider with a high Medicaid dollar volume, of for example, $5000 a month. A six month payment delay means the physician is making a $30,000 interest-free loan to the state perhaps while at the same time borrowing (and paying interest) on a similar amount in order to maintain an adequate cash flow. The problem is compounded if claims are denied without adequate explanation or opportunity for correction. From a business point of view, discounting or "factoring" claims to gain immediate payment may save money in terms of interest costs, not to mention the cost to the provider of the bookkeeping to account for which claims the state has paid and which have not been paid, etc. It must also be remembered that high dollar providers are not necessarily engaging in fraud; in many cases high volume providers are the ones most needed by the program because they are located in low-income accessible areas accessible to most recipients.

It should be noted that factoring is an accepted business practice which millions of American businesses use through the acceptance of credit cards. The business pays a percentage of the face value to the credit card company for immediate and guaranteed payment of the balance while the credit card company assumes the risk of collection. Factoring, however, is a problem to the Medicaid program for several reasons. First, factoring firms are in a position to abuse their clients; they may initially charge a reasonable percentage of claims for their services, but as the provider becomes locked into the system and is dependent on immediate payment, the percentage amount may be increased. The factor may actually coerce the provider into remaining involved and paying a higher percentage. Second, there is an incentive to both the provider and the factor to increase patient utilization of services (either actual utilization or billed utilization) or engage in other spurious activities to make more money. A provider may bill for more services than he normally would to make up the deficit from paying the factor, or the provider or factor may submit false claims. The more money the provider makes, the more money the factor makes, so there is double encouragement of overutilization or fraud.

Finally, factoring firms in some places have corrupted state agency employees to speed up or improve the processing of the factor's claims. If the factor can get preferential treatment by claims processing staff, he has reduced his interest cost (or foregone interest income) and his risk substantially.

DHEW has attempted to deal with the factoring problem. The department has promulgated a regulation with respect to factoring (45 CFR 249.31, Prohibition Against Reassignment of Claims to Benefits). The regulation states that the state agency may not pay a "collection agency or service bureau which (or an individual who) advances money to a provider for his accounts receivable which have been assigned or sold, or otherwise transferred, including transfer through the use of power of attorney...for an added fee or a deduction of a portion of such accounts receivable." The regulation goes on to state that this does not include billing agents or accountants who perform the billing service for a fee "reasonably related to the cost of processing the billings" rather than on a percentage of claims.

Since the regulation has been in effect for only a few months, there is as yet little evidence concerning its adequacy or inadequacy. The regulation superceded a regulation which was circumvented by providers and factors through the use of a power of attorney which the new regulation addresses.

Although there is no conclusive experience with enforcement of the new reassignment of claims language, it is questionable whether it is not also susceptible to circumvention. The key distinction in the language is the basis on which the factor is paid—percentage or cost related. Therefore, the pursuance of such a case would require a detailed audit of the claims involved, the provider's records, and the factor's records. Gaining such access to records, particularly factor's records, could prove difficult in practice.

Even if such access could be achieved and the regulation is enforceable, the cost of mounting such an investigation would be substantial. Therefore, the value of continuing to attempt to regulate factoring out of existence appears to have little additional benefit over prompt payment of claims and existing regulations with respect to necessity and appropriateness

of services and submission of claims either by the provider or the factor for services not rendered which is clearly punishable within the scope of existing regulations. The best way of eliminating factoring involves efficient claims processing systems and prompt payment of claims which makes factoring unnecessary. As a part of such a system, providers should receive regular status reports covering all claims not yet paid, as is done in Washington. Federal regulations requiring prompt payment are likely to be more productive than are anti-factory regulations.

A claims processing system organized to pay claims promptly and efficiently would not only benefit this one type of fraud control, it also would benefit the program in many other management areas. For example, one state had a major problem with submission of duplicate bills. This occurred in many cases not because the providers were attempting to defraud the program but because after waiting several months for payment, providers assumed the nonpaid claim had been lost and submitted a second claim just as they would rebill a private patient after a period of time. Since the state's claims processing system could not detect duplicate claims, both claims were eventually paid. This exemplifies also how slow claims payment and poor quality claims payment (no check for duplicate bills) in the absence of the MMIS are usually associated and how they induce fraud or apparent fraud. This problem, like factoring, would not occur with a properly programmed and managed claims processing system.

F. Prior Authorization

States generally use requirements for prior authorizations for certain services as a method for controlling utilization, particularly in relation to costly services. Prior authorization, like many other features which have been part of the basic program structure for many years, if often performed mechanistically and has not been reviewed for applicability to new problems and situations.

Only a few jurisdictions reviewed for this study understood the potential for the use of prior authorizations to control fraud and abuse. Thus, the prior authorization system is a good example of the fragmented approach which has been taken with respect to fraud and abuse control. State agencies and the federal government have generally focused on fraud as an investigation and penalty function. In effect, the state fraud investigations unit is

perceived as the total fraud control program. Other preexisting program functions or activities and their relationship or value to fraud control, particularly in the prevention area, have been largely ignored.

Historically, prior authorization has been related to medical necessity and is conducted by an organizational unit not associated with the fraud unit. It has, therefore, not usually been reviewed for its applicability to fraud control. However, medical necessity and appropriateness of treatment is at the heart of many program abuse and some fraud issues. This application of prior authorization would not be an inappropriate use of medical judgment since prior authorization is currently used primarily to control costs, which are a management rather than a medical concern.

Use of prior authorizations can be an integral part of fraud and abuse control programs if "priors" are also required for types of services or categories of providers where fraud and abuse is a particular problem. Use of prior authorization in this way would not only have benefit in preventing fraud or abuse with respect to the individual requests received, but also have benefit in the decreased likelihood that fraud or abuse would be attempted if a request for authorization were required.

As part of any DHEW review of state agency's fraud control programs, the prior authorization system could be reviewed. In addition, each state agency could review its requirements for prior authorization, in light of fraud and abuse problem areas.

Before prior authorizations are required for additional services, however, management of the prior authorization program should be reviewed. An inefficient prior authorization system can cause more problems than it solves. In fact, in one state a case of apparent program abuse was justified by the abusing provider as a method for dealing with the inefficient prior authorization system. In this particular case, a dentist serving a nursing home apparently provided quality services. However, he came to the attention of the provider review unit, in part, because he had requested prior authorizations for dental prosthesis on almost every patient in the home. A visit by the program's dental consultant confirmed that not all patients wanted or needed prosthesis and that some had not even seen the dentist involved. The dentist's explanation was that he knew he would need prior authorization for all prosthesis, which would probably be required

eventually for many of the patients. Since it took so long to get "priors" approved, he requested them on all the patients so he would be able to immediately provide services for those patients for which prostheses were appropriate when he was ready to do the work. This is not an unreasonable explanation since it was then taking 3 to 6 months to get dental "priors" authorized. In this case inefficiencies in the "front end" of the system created additional work for the provider review unit at the "back end" of the system. Another example of management weaknesses which destroy the value of prior authorizations is claims processing systems which pay claims for services requiring "priors" even if a prior has not been issued.

Suggestions for improving the prior authorization system include:

— prioritizing of requests based on urgency of services;

— telephone "hotlines" for urgent requests;

— use of nurses or other types of health personnel to handle routine requests within guidelines proscribed by specialty consultants.

— increasing the FFP for Medical professionals involved in the prior authorization process and in review of potential fraud or abuse cases from 75% to 90%.

— increase the availability of medical consultants to review "difficult" prior authorization requests.

To summarize, the prior authorization system in each state should be reviewed by both the state agency and DHEW as to its management and its utility for addressing fraud and abuse issues.

2. Actions which Prevent Payment of Fraudulent of Suspicious Provider Claims

The preceding sections dealt with options for preventing or reducing the extent of attempts to abuse or defraud the Medicaid system. This section discusses concepts for preventing attempted abuse or fraud schemes from being successful in obtaining program dollars. Thus in this section, the payments processing system assumes primary importance. A major goal of any Medicaid claims processing system, in addition to prompt and accurate payment of legitimate claims, should be to prevent the payment of individual claims which are not legitimate. The claims processing system in itself cannot be expected to prevent payment of claims which in themselves appear to be legitimate and are demonstrated to be fraudulent or abusive only in relation to other

claims presented by a provider in question or in relation to other services provided to a given recipient. Fraud or abuse of this type should be detected by the Surveillance and Utilization Review Unit (S/UR); options for S/UR detection are to be discussed in Chapter V.

A. Computerized Claims Processing

Although it would be difficult to imagine a Medicaid claims processing system which is not highly computerized, such systems still exist in some states. In Pennsylvania, for example, claims are checked and processed by hundreds of clerks in the state treasury department.* The clerks, given their workload, are unable to make only the most basic checks before authorizing a claim for payment. Even if their workloads permitted, it would be extremely difficult and time consuming for clerks to check for duplicate billings, compare diagnoses with treatments, check for prior authorizations, etc. A computer system, however, can do all of these things and also conduct other checks routinely on all bills with a minimum of human intervention.

The many benefits of computerization of Medicaid claims processing have long been recognized by DHEW, Congress, and several states. Congress authorized development of the Medicaid Management Information System (MMIS) which processes claims as well as serving other functions. Congress also authorized higher federal matching (FFP) for installation and operation of the MMIS in the States. DHEW then developed the model system.** Some states have adopted all or part of the system. Other states, not yet having implemented the MMIS, have contracted out for Medicaid claims processing or

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*Some claims are processed by computer in Pennsylvania. Paid Prescriptions processes drug claims, and Blue Shield processes hospital-related claims. All other claims are processed by clerks. A retrospective review of 5% of all paid claims is conducted each month. This activity, of course, is detection-related, not prevention of the payment of fraudulent claims in the first instance.

**For a detailed description of the MMIS see: U.S. Department of Health, Education, and Welfare, Medicaid Management Information System, five volumes, 1973. Available from the National Technical Information Service.

have installed special purpose claims processing computer software on state computers.

Nationally, the current level of adoption of sophisticated computerized claims processing by state Medicaid agencies in inadequate, not only from the perspective of fraud and abuse control, but also from the perspective of general efficient program administration. We believe that the best long term solution to the current situation is universal adoption of the MMIS or other computerized processing systems.* It should be noted that the project staff neither was charged with conducting nor conducted a detailed examination of the details of systems such as the MMIS or their efficiency. Nevertheless, it is clear that the MMIS and other systems contain features which are essential to fraud control in general and to fraud control in terms of claims processing in particular.

The MMIS Claims Processing Subsystem is designed to minimize the payment of suspicious or fraudulent claims. The system edits all claims submitted by providers; it checks for compatibility of procedures and diagnoses (as well as for the compatibility of diagnoses and procedures for classes of patients, e.g., sex-specific procedures claimed for a patient of the wrong sex); it verifies that the claiming provider was eligible to provide services when the claimed service was rendered; it verifies that the provider was authorized to perform the type of service claimed; it verifies the eligibility of the recipient at the time the claimed service was provided; and it also checks to determine that the claim is not a duplicate of a previously processed claim and that the service claimed is not in conflict with a previously processed claim. Although it is not a matter of fraud control, the MMIS also checks to determine if other insurers are recorded in the file for the recipient in question so third party liability may be assigned if possible.

Besides containing the claims processing subsystem, the MMIS also builds and maintains data files concerning providers and recipients, including data files useful for surveillance and utilization review (S/UR). Other computer systems also operate on a post-payment basis. The S/UR subsystem is discussed in Chapter V in relation to fraud and abuse detection. Because of its claims

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*Such systems include the "Fraud Detection System" undergoing pilot testing in New Jersey and the "Automated Overutilization and Erroneous Billings Audits" system.

processing and S/UR capabilities, we believe that universal adoption of the MMIS would be an important step in Medicaid fraud and abuse control. The MMIS in itself will not control fraud and abuse, of course. Indeed, it would probably be counterproductive to install the MMIS without also providing additional investigators to follow up all the leads which will be undoubtedly generated by the MMIS as it is implemented.

B. Coordination of Claims Payment with Rate Setting Agencies

Because of the increasing costs associated with medical care, both the Federal government and the states have launched efforts to control health care costs. At the federal level cost control initiatives have taken the forms of health planning legislation, PSRO legislation, and proposed ceilings on hospital cost increases. States have used other methods. Four states (Massachusetts, Maryland, Washington, and Connecticut) have established regulatory commissions which set or approve hospital rates, much as the rates for public utilities are set or approved. Depending on the success of the current federal cost control measures and depending on the adoption of new federal cost control devices, possibly built into a national health insurance proposal, additional states may establish rate setting commissions.

It is clear that in states which have established rate setting commissions, the Medicaid claims payment process must be highly coordinated with the rate setting agency. Medicaid should not pay $10 for a procedure for which a rate of $5 has been established. The real problem in this regard, however, is much more complex than simple overpayments; institutional accounting and billing procedures are involved. The cost allocation and billing systems of hospitals and other health care institutions are as complex as the services provided in these institutions. Obviously, institutions should bill Medicaid only for the approved amount for any service and the claims processing system should pay only the approved amount. Complications can easily arise, however. A nursing home, for example, might bill the Medicaid agency separately for a service already covered in its basic per diem rate as approved by the Rate Setting

Commission. Regardless of whether the separate billing was made through fraud or error, the claims processing system should reject the separate bill in such circumstances. To do so, however, the claims processors msut have detailed information from the rate setters concerning what services are included in the basic rates of various classes of institutions (or even various specific institution). In addition, the claims processors need information concerning what subsidiary services are included in the rates set for umbrella services, both as provided by institutions and as supplied by all other providers. The claims processing system should be designed in such a way as to prevent payment twice for a given service which may be included in a daily rate or in an umbrella service.

III. PREVENTION OF RECIPIENT FRAUD AND ABUSE

Although it is widely believed that recipient fraud and abuse is of secondary importance to provider fraud and abuse in Medicaid, no firm data is available to either confirm or deny this belief. Given the fact that the program pays money to providers and only provides services to recipients, it is likely, however, that the greatest program losses to fraud and abuse actually are provider related. Nevertheless, recipient fraud and abuse are clearly worthy of additional attention at both the federal and the state levels. Recipient fraud and recipient abuse are discussed separately below along with options for their control.

1. Recipient Fraud

As commonly defined, opportunities for recipient fraud in the Medicaid program are limited. While fraud in eligibility could be classified as a type of Medicaid fraud, since Medicaid eligibility is highly linked to AFDC or SSI eligibility and the activities of case workers, we do not consider questions of Medicaid eligibility to be questions of Medicaid fraud. The reader interested in fraud control in relation to eligibility is referred to the General Research Corporation AFDC fraud options report, which is a companion to this volume.

We thus restrict our definition of Medicaid recipient fraud to instances in which a recipient allows another person to use his or her Medicaid card to gain services to which the individual using the card is not entitled. Legally speaking, this may be recipient fraud only in those circumstances in which the eligible recipient gains something of value for allowing another person to use his card. (It clearly is fraud on the part of the person using an eligible recipient's card in all instances.) In any event, we discuss under the title of recipient fraud any instances in which a Medicaid card is not used by the person to whom it was issued, regardless of whether the eligible recipient willfully participates in the scheme. Penalties should always be assessed on the user of the card; penalties should only be assessed on the eligible

recipient if he or she was knowingly involved in the fraudulent use.

Two methods are available to prevent use of Medicaid cards by the wrong individuals. Because of their varying benefits, both could be adopted. First, photo identification cards could be issued to Medicaid recipients. These cards ideally could be similar to credit cards. Claims without the imprint of a recipient's photo Medicaid card would not be accepted by the Agency for payment. The photo identification cards should be accompanied by an "authorization to use" card printed by computer or a validation sticker to be attached to the photo Medicaid card. Either the validation sticker or separate "authorization to use" card could be issued monthly to prevent use of photo Medicaid cards by persons no longer eligible for benefits.

Use of a photo Medicaid card has several advantages which would justify the initial investment in issuing such cards. First, use of photo Medicaid cards would make it less likely that nonrecipients could use a recipient's card to gain services. No statistics are available which indicate the extent of losses resulting from fraudulent use of Medicaid cards by noneligibles, but such use may be substantial. Second, use of photo Medicaid cards would lessen the street value of a Medicaid card, and thus reduce incentives for theft of cards. Thirdly, a photo Medicaid card could double as an identification card for purposes of cashing AFDC checks. This would make it easier for AFDC recipients to cash their checks and would lessen the street value of stolen AFDC checks since they would be difficult to cash without a photo identification (Medicaid) card.

Photo identification cards will only reduce fraudulent use of Medicaid cards if providers cooperate by refusing service to persons who attempt to use a Medicaid card belonging to another person. While most providers would cooperate, a few would not care whose card was used as long as they were paid by Medicaid. A second method, which is as much detection as prevention, is recommended to help control this problem. This method is the maintenance of patient diagnosis and treatment profiles. Such profiles are a feature of the MMIS Surveillance and

Utilization Review subsystem. Incompatible or highly unusual combinations of diagnoses revealed in the profiles indicate likely fraudulent use of Medicaid services. Since patient profiles are built into the MMIS, they should obviously be used for fraud control. We believe that use of photo Medicaid cards, however, is a better preventive technique.

2. Recipient Abuse

Although recipient fraud is clearly illegal, recipient abuse is a much more questionable area. Abuse is defined in program regulations if it is operationally defined at all. Generally, however, instances of abuse are recognizable even if they are not currently strictly defined before the fact in all instances. Generally, Medicaid recipient abuse is thought of as involving gross overutilization of services at the initiation of the recipient for no valid medical purpose. "Doctor shopping" and "pharmacy shopping" in which a recipient visits many providers each month (often to gain multiple prescriptions for drugs with high street values) is an example. Another example involves a recipient's making repeated visits to a provider for very minor or nonexistent ailments. Similarly, a recipient's repeated loss or breakage of eyeglasses, continually replaced by Medicaid, might be another abuse.

Abuse can be reduced through use of several techniques. Provider "shopping" can be detected through use of recipient profiles and can be eliminated by establishment of regulations specifying that recipients found to have engaged in "shopping" must receive all their care from a single provider of each type (of their choosing) until they notify the Agency that they wish to change providers.* Ohio is an example of a state with such a regulation. Although provider-initiated referrals are allowed, these recipients are "locked in" to a single provider at a time. Changing that provider requires the filing of a form with the agency.

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*Such recipients should receive specially encoded Medicaid cards so providers will recognize that they should not provide services without specific authorization.

This method discourages most provider "shoppers." It should be noted that this technique does not violate the federal requirement of free choice of provider (45 CFR 249.20) since recipients can choose any provider they like and change their choice as often as they like so long as they notify the Medicaid agency of their changed choice. Since a requirement of this kind is not needed for most recipients and would be burdensome on the Agency if it were required for all recipients, its implementation presupposes the existence of a method for identifying provider "shoppers." Such identifications can be made through use of MMIS reports of high volume recipients and recipient profiles.

Other recipient abuses can also be prevented if information is available to identify abusing recipients. Recipients who grossly overuse (or try to overuse) the services of a single provider can also be identified through use of the MMIS. This type of overutilization can be reduced by adopting a system of prior authorization of services tailored to each abusing recipient. These recipients could be issued Medicaid cards which indicate either in code or in plain English that no service (or no service of a given type) is to be provided to that recipient without authorization from the Medicaid Agency. Implementation of this option, of course, presupposes the existence of a prior authorization unit able to quickly respond to all requests for authorizations.

The last major type of recipient abuse can also be prevented through use of a prior authorization system. Prior authorizations can be required before high value medical equipment or items such as eyeglasses are supplied. Similarly, a limit is often placed on the quantity of medical equipment or items which will be supplied in a given period. Both of these measures reduce the likelihood that such items will be supplied when unneeded by the recipient or supplied to a recipient for use by someone else.

IV. PREVENTION OF MEDICAID AGENCY EMPLOYEE FRAUD AND ABUSE

Employee fraud or abuse in Medicaid is a very minor problem in the states visited during the course of the GRC study. We believe that the problem is quite likely to be minor in other states as well, primarily because the opportunities and incentives for an employee to commit fraud are limited. Recipient eligibility is most often a by-product of AFDC or SSI eligibility, so opportunities for Medicaid agency personnel to establish false cases are limited, although it may be possible for them to get false Medicaid cards. It is also quite difficult for an employee to establish a false provider and then to bill the agency for that provider's services. Thus any employee fraud is most likely to involve favored treatment for particular providers or factors. Reports that some factoring firms have received special treatment in terms of prompt payment of claims they submitted are well known. Such special treatment should be prevented by designing the claims processing system in such a way that any special handling of claims outside the routine payments process is automatically reported to top Agency management.

Employees may also sell or give valuable information to providers. Employees can, for example, provide information on the workings of the review system, exceptions criteria, etc. With this information a provider could defraud the program while remaining just below exceptions standards. Thus information on exceptions criteria and standards and the workings of the review process should be restricted to as few employees as practical.

Another potential problem involves employees in claims processing providing information to favored providers concerning the best time to submit "questionable" bills. We know of at least one state in which the normal claims processing edits are periodically overridden to clear out a backlog of unpaid claims. While we are not aware of any instance in which the timing of such overrides was made available to providers, such information would obviously be valuable to a provider desiring to defraud the program. This potential abuse can be prevented by using a claims processing system which is adequate to the demands placed upon it, so normal

edits never are overridden in an effort to reduce a backlog. We believe normal claims editing should never be relaxed under any circumstances.

V. DETECTION OF FRAUD AND ABUSE

The preceding three chapters dealt with prevention of provider, recipient, and employee fraud and abuse. This chapter discusses detection of fraud and abuse which is not prevented. Primary attention is directed at computerized techniques which can identify patterns of claims for services which are likely to indicate fraud or abuse. This is in contrast to the claims processing system which should identify (and not pay) claims which are individually fraudulent. Other methods of detecting fraud and abuse not based on patterns of utilization are also discussed.

1. Identification of Fraudulent or Abusive Utilization Patterns

Unusual patterns of utilization are a major indicator of fraud or abuse. For example, a physician who bills for an unusually high percentage of first visits, as opposed to follow-up office visits, may be fraudulently billing follow-ups as initial visits to gain the higher fee for initial visits. Similarly, a physician who regularly bills for a larger number of expensive laboratory services than seems appropriate for his specialty may be engaging in a kick-back scheme with a medical laboratory. Examination of profiles of services provided to patients at a given nursing home can be similarly revealing, as can examination of the services provided to a single recipient. And examination of referral patterns can reveal "Medicaid Mills" and "pingponging" of patients. Another example concerns pharmacies, for which profile analysis may reveal prescription splitting. In the case of recipients, profile analysis may reveal that incompatible services were provided to a single recipient, and thus indicate that the recipient's Medicaid card has been fraudulently used. Or recipient profile analysis may reveal abusive overutilization by a recipient, thus calling for counseling of the recipient or other actions.

As in the case in claims processing, the key to detection of fraudulent or abusive utilization patterns in a sophisticated computer system which can analyze claims information to generate utilization pattern reports for classes or providers, individual providers, classes of recipients, and individual recipients. The system should be designed to automatically

identify those providers or recipients who bill for or receive care which is substantially different from the care billed by similar providers or provided to similar recipients. Important differences can be either in terms of the nature of the services involved or the volume of services provided or received. The system should also be designed so that it can on request provide detailed breakdowns of all services billed by a given provider or rendered to a given recipient. This information can be of major value, first, in determining if the pattern really does indicate fraud or abuse and, second, in conducting an investigation if fraud or abuse is determined to be likely in the case at hand.

The Surveillance and Utilization Review (S/UR) subsystem of the MMIS is designed to provide the necessary profiles. Although it should again be noted that it was not our purpose to conduct an evaluation of the MMIS, we believe that universal adoption of the MMIS would be of great value in this area of fraud control. We know that states which have adopted the MMIS and the S/UR subsystem have had to "fine tune" the system's exceptions criteria to prevent generating so many leads that the available investigators cannot keep up with the workload. Other states adopting the MMIS should also expect to go through a period of adjustment during which the exceptions criteria are made realistic for the state in question.

The MMIS S/UR subsystem provides a number of highly desirable reports:*

- It maintains files on the activities and characteristics of Medicaid recipients, taking information from claims file.
- It classifies participants (providers and recipients) into groups composed of similar participants, on the basis of both demographic characteristics and on medical characteristics.
- It develops statistical profiles of each peer group for use as a base line for evaluations and exceptions reporting.
- It develops a statistical profile of each provider and recipient which can be compared to the peer group profiles.

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*See U. S. Department of Health, Education, and Welfare, Medicaid Management Information System, Volume III, 1973. National Technical Information Service Document # PB-236-553.

- It evaluates individual providers and recipients against their peers.
- It reports all providers and recipients who deviate significantly (as defined in exceptions criteria) from their peer group norm.
- It produces "claim detail reports" for use by investigators working on suspected fraud or abuse.

Other computer systems can also be used to detect fraud. These include the "Fraud Detection System" and the "Automated Overutilization and Erroneous Billings Audits" system. In addition, the general HEW audit program, HEWCAS, can be used for post-payment review of claims. Implementation of the MMIS S/UR component or other computerized systems serve as the basis of an effective detection system, both for fraud and for abuse. Effective use of these systems, however, implies that adequate personnel are available to examine computer reports and determine which ones are candidates for detailed investigation. Without adequate personnel to screen the reports and to investigate cases as needed, the entire fraud control effort is likely to become bogged down in a sea of paper as small staffs are unable to keep up with the volume of leads generated by the computer. This problem should be diminished as the computer systems become more sophisticated and as staff sizes are increased in reaction to the new fraud related workload.

2. Maintenance of Detailed Patient Records in Abused Areas

Although implementation of the MMIS is a good basic step in fraud detection, a number of states supplement it with other methods. One of these is the maintenance of detailed medical records concerning patients, particularly prone to abuse. These records help in two ways. First, they can be used to detect and later prosecute suspected fraud cases involving services not actually delivered but which were billed. For example, a dentist may bill for filling a tooth which he had previously charged the Medicaid agency for removing. Maintenance of detailed dental records can detect such schemes, as Virginia has demonstrated through its computerization of dental records. If the records are used along with a system of prior authorizations, such fraudulent billing can be eliminated entirely.

The maintenance of detailed medical records may also be used to detect suspected cases of recipient abuse in terms of the lending of Medicaid cards. Highly unusual medical records which are easily

detected as fraudulent or abusive can result from the use of a card by several individuals. First priority in this area, however, should be given to preventing the practice in the first place, not detecting it once it has taken place. Prevention of the sharing of Medicaid cards is discussed in the preceding chapter.

3. Improved Use of "Explanations of Medicaid Benefits"

Currently Section 1903(a)(3)(B) of the Social Security Act requires "prompt written notice to each individual who is furnished services covered by the plan [Medicaid] of the services so covered, the name of the person furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services" if the state is to receive 75% matching for operation of its MMIS. These written notices, generally called "explanations of Medicaid benefits" (EOMBs) are generally mailed to each recipient who received services each month. The recipient presumably notifies the Medicaid agency if a service listed on the form was not received as described. Thus EOMBs could be an important detection technique.

Experience with EOMBs, however, has shown them to be less efficient in detecting fraud than they might be, in contrast to the experience with Explanations of Benefits in the Medicare and CHAMPUS programs. A number of factors may be responsible for this fact. First, as implemented by a few states, EOMBs are difficult to understand. Services may be referred to in language or in computer code numbers which the recipient cannot understand. The layout of the forms also may not be clear. One visited state reported that confusion was so great that some recipients initially thought they had to pay the amounts listed on the forms; other recipients tried to cash the forms. Given the confusion resulting from EOMBs (not to mention the fact that the EOMB requirement has delayed the installation of the MMIS in some states), it would be desirable for Congress to repeal the 100% EOMB requirement, as specified in proposed amendments to the Social Security Act.

This is not to say, however, that the EOMB concept should be scrapped entirely. Instead, as demonstrated in Oklahoma, states can use well designed EOMB-type forms sent to a specially selected sample of recipients, to generate prosecutable fraud cases. When visited, Oklahoma sent out 100% EOMBs as required to receive the 75% match, but Oklahoma also sent out a similar form to recipients listed as receiving services from suspected providers. These forms included not only a request that the forms be reviewed and returned but also a pre-stamped and addressed envelope for the return of the forms. This technique generated a high response rate and several prosecutable cases. This approach has significant advantages. First, it is relatively cheap since only a relatively small number of mailings is involved, not the entire caseload. Second, recipients tend to take the special EOMBs more seriously since they only rarely receive one; it is not regarded as a monthly piece of junk mail from the agency. Third, the fact that the EOMBs are targeted on suspected providers means that the agency is not inundated with forms which it must process each month. Instead, it receives a small number of forms which are easily examined and much more likely to contain information of interest. Mandated implementation of an approach similar to Oklahoma's targeted special EOMBs is a desirable alternative to the 100% EOMB requirement. At a bare minimum, sending EOMBs to nursing homes and institutions for the mentally retarded should be eliminated.

4. Improve Recipient Reporting of Provider Abuse

Another option, which is in some ways similar to EOMBs, is to improve methods used to obtain reports from recipients of inadequate or abusive medical care. Indeed, such improved methods could be added to the EOMB forms if the EOMB requirement is maintained. This option could be implemented by enclosing appropriate material with other Agency mailings. Basically what is needed is a regular notification concerning a recipient's right to receive adequate care as is appropriate for his or her needs. The notice should also point out that the Agency is interested in learning of cases in which the recipient did not receive care in a professional manner or in which the recipient believes the provider provided services which were unnecessary. Instances of care

being rendered in a nonprofessional way (patients being examined in hallways or open offices while in full view of other patients and office personnel) are well known; equally well known are instances of unnecessary services, such as fitting eyeglasses for every patient who comes to a clinic. While such abuses are most common in "Medicaid Mills," some abuse of this type may also occur in other settings. If the agency emphasized its interest in such cases by providing a postage paid "complaint" form to recipients or through provision of a toll free telephone line for such reports, and if the agency emphasized that all such "complaints" would be held strictly confidential so that providers would never know who reported them, a significant number of actionable abuse cases might be detected. Such a system might also generate a large number of unfounded complaints. We know of no information concerning the proportion of such reports which would be worthwhile to the agency and the cost effectiveness of such a program.

5. Improved Coordination with Institutional Licensing and Inspection Authorities

Another area in which increased emphasis on fraud control would be beneficial is that of coordination with institutional inspectors and licensing authorities. Indeed, the importance of such coordination is already inferred in law through Section 1903(a)(3)(B)(4) of the Social Security Act, which authorizes 100% federal funds for the training and compensation of health and safety inspectors for institutions of long term care. It should be noted that these personnel can be either employees of the agency itself or of another agency. In any event, the inspectors should be alert to and report to the Medicaid agency about matters other than just health and safety issues. An inspector who was told that a given long term care facility was billing for physical therapy services for 90% of its patients could relatively easily gain an impression concerning whether adequate facilities and personnel were available to provide the services reported. Inspectors could also identify suspected "Medicaid Mills." Such actions could be of great value to the Agency and would place little additional burden on inspectors.

6. Use of PSROs to Detect Fraudulent and Abusive Practices

Another area where reliance may profitably be placed on other agencies to aid in the detection of fraud and abuse concerns the Professional Standards Review Organization Program. As the 203 PSROs are organized and become fully operational throughout the country, they can have an impact on fraud and abuse as well as on unnecessary hospital utilization. Besides simply denying unnecessary hospital admissions and continued stays, PSROs should be requested (or required, if necessary) to report those physicians who have unusually high numbers or proportions of denials of either admission certifications or of continued stay certifications. A high denial rate may well be correlated with other abusive practices which do not come within the purview of the PSRO, such as abusive practices within the physician's office. These matters, of course, would be of interest to the Medicaid agency. The agency could conduct claims reviews for providers reported by the PSRO to determine if, indeed, there were abusive practices in evidence. If there were, appropriate actions could be taken. Such reporting by PSROs would place little additional burden on them and could be of significant value to the Medicaid agency in detecting some types of abuse.

VI. INVESTIGATION

While prevention and early detection are critical to the control of fraud in the Medicaid program, investigation is an equally critical function. Investigation must be understood as relating to both the Medicaid fraud and the Medicaid abuse problem. Fraud involves willful misrepresentation of facts in the commission of activities for which criminal penalties are available. Thus, for Medicaid fraudulent activities include kickback schemes, shorting and kiting prescriptions, billing for services not rendered, etc. All of these acts involve providers willfully or intentionally attempting to gain payments from the program in violation of law or Medicaid regulations. Abuse involves violation of program regulations or conduct involving questionable ethical or medical judgments (including such judgments made by recipients) for which criminal penalties are not available. Such activities can include unnecessary referrals (overutilization), frivolous visits, questionable quality of care, etc. Although there may be a fine line between fraud or abuse based on the issue of the intent of the provider, in some jurisdictions more program dollars are classified as misspent through abuse of the program than through actual criminal fraud. Therefore, the Medicaid program must be able to identify, investigate, and implement disincentives and penalties for both fraud and abuse.

Investigation of fraud and investigation of abuse require different types of skills. Fraud investigations require an investigator with the skills of an insurance investigator or a police fraud investigator, primarily because knowledge of specialized investigative techniques is required to identify and preserve evidence which will serve the needs of a criminal prosecution. A relatively limited knowledge of the Medicaid program and medical issues is required because most types of Medicaid provider fraud is similar to other types of commercial fraud and because fraud investigators can call on Medicaid program staff for medical judgments or interpretation of regulations when needed. Investigations of Medicaid abuse on the other hand need special working

knowledge of Medicaid program regulations and health care delivery practices and issues. Investigations of abuse must be based on the recognition that both determination of what constitutes abuse and determination of penalties in any given case are basically administrative decisions.

The best fraud and abuse control programs recognize that fraud and abuse are different and have established separate mechanisms for dealing with each. The succeeding subsections of this chapter, therefore, address the basic procedures and processes of these two problem areas and the available options with respect to each. The reader should be aware that this section is directly related to the following chapter on outcomes since investigations are only as useful as the outcomes which result from the investigations. The investigation of abuse also ties directly to the discussion of the importance of strong regulations in the introduction to this report because abuse only exists to the extent that it has been defined as such in the regulations.

1. Utilization of Detection Information

As discussed in an earlier chapter of this report, a strong detection system is essential. There is no evidence to suggest that random complaints, hotlines, etc., serve as an effective mechanism for detecting cases to be investigated. These sources can be valuable but only to supplement a strong detection system. The strongest detection mechanism is the combination of a computerized claims processing system that provides various types of output reports with staffing levels sufficient for the program to be truly able to investigate detected cases and review and supervise providers on a regular basis.

It should be noted that there is a close relationship between the sophistication of its claims processing system and the numbers of investigators required by a state. A manual system or an unsophisticated computerized claims processing system generally detects only a limited number of suspected fraud cases. Most fraudulent claims are simply paid; therefore, few investigators may be needed to handle the few cases

which are detected.* As the sophistication of the claims processing system increases, up a given level, the number of investigators needed greatly increases. The implementation of a moderately sophisticated computerized system which generates many exceptions will likely require a large number of investigators to follow up the detected cases, even though a large proportion of the leads reported by the computer may be entirely legitimate. A large number of investigators is necessary since there is no way to identify the genuine instances of fraud or abuse without an investigation. As the claims processing becomes more sophisticated, however, the requirements for investigations decrease. If the system is programmed to report only those few situations which are most likely to involve fraud or abuse, as indicated by the results of previous investigations, then the fewer cases reported can be investigated by fewer investigators who spend little time working on cases which prove to be not fraud or abuse. The relationship between the claims processing system and the number of investigators required is summarized in Exhibit 1.

Regardless of the nature of the case detection system, at the first level of the investigative process there must always be sufficient staff to review the detection information and make judgments as to the importance and priority of the various "cases" identified. This critical function is usually conducted by the surveillance and utilization review (S/UR) unit or program abuse control unit. Except for provider's dollar volume, which is a very unsophisticated measure, no single indicator is especially useful in identifying <u>fraud</u>. Instead, <u>fraud</u> is usually identified after an abuse is initially identified and investigated. For example, an initial investigation of high utilization may lead to the conclusion that the provider is simply abusing

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*However, the lack of sophisticated computer systems may result in more investigative time per case, thereby, perhaps, increasing the necessary size of the investigative staff. When sufficient data cannot be produced and reviewed "in house," the time spent in lengthy field investigations to check out those cases which are detected or anonymous "tips" which come to the attention of the agency may increase dramatically.

Exhibit 1

THE RELATIONSHIP BETWEEN CLAIMS PROCESSING SYSTEMS AND NECESSARY INVESTIGATIVE STAFFING

Claims Processing System	Number of Exceptions Generated by System	Proportion of Exceptions Which Are Actually Fraud or Abuse	Number of Investigators Needed
Unsophisticated	Few	Variable	Few to Moderate*
Moderately Sophisticated	Many	Low	Many
Sophisticated	Few to Moderate	High	Few to Moderate

*depending on amount of information available for screening out "non-cases."

the program or it may lead to the discovery that the high utilization is part of a kickback scheme. This screening or identification function requires the skills of a health professional who can analyze the types, pattern, and appropriateness of services provided. Such professionals are usually found in program abuse or S/UR units. In states which are organized with S/UR program abuse units and "fraud squads" most of the cases investigated by the "fraud squad" were detected, initially screened and referred by the S/UR program abuse control unit.

The authors wish to emphasize the necessity of the function that screens the detection information and identifies potential fraud cases. This is necessary regardless of the sophistication of the computer system. The word investigator is usually used or interpreted to mean field investigators with police agency or other criminal investigation backgrounds. It is of great importance that the need for other skills be recognized, that this case identification function not be overlooked, and that sufficient staff exist to perform this function efficiently.

Unfortunately, in some states with a shortage of staff, priorities have been set so that a "detected" case is simply monitored for several reporting quarters to assure that the detection is not an aberration. This, of course, means that some cases of fraud and abuse are allowed to continue for several quarters with the resultant additional misspent funds. An adequate program abuse unit coupled with a sophisticated computer system could prevent this. Federal standards regarding staff size in the S/UR and investigations area may well be desirable. Current federal regulations concerning the conduct of utilization control and review (45 CFR 250.18 and 250.19) are primarily concerned with control of institutional inpatient series and costs and do not directly address staffing requirements for effective conduct of the functions. How states could comply with new standards for staffing leads directly to the following point.

2. Increased FFP for Investigators and Investigative Training

The option that Federal Funding Participation (FFP) be increased through legislative amendment to provide an increased match share to states for the support of fraud investigators is not novel. Discussion on this subject has involved a range of funding levels from 75% to 100%, paralleling the current increased match for professional medical personnel, MIS systems training, and family planning. The authors have no strong opinion as to the optimal level except to say that it should be remembered that state as well as federal funds are saved through good fraud control, so an excessively large carrot may not be required. We do believe, however, that a higher match for professional medical personnel involved in fraud and abuse control (to perhaps 90%) would be desirable, particularly in light of the importance of professional opinion in the program abuse area. A 90% match for medical personnel in this one area should increase their availability. Two issues concerning the general implementation of increased FFP which should be considered in selecting the matching percentage. First, based on the previous section of this chapter, the increased match should be broadly available to program abuse control type units in addition to police-type investigations units. This is important for two reasons: (1) the necessity of the screening and case identification function discussed previously, and (2) the great financial

loss to the program through abuse in addition to fraud. The available experience suggests that the number of actual fraud schemes is relatively small compared to the number of program abuse cases. While fraud must be controlled or eliminated, abuse must also be addressed, especially since it ties directly to one aspect of the issue of control of costs in a national health insurance program.

Therefore, it is important that the legislation must not be drawn or interpreted so as to severely limit the ways in which DHEW may apply the funds. Police-type "fraud squads" cannot alone deal with fraud and abuse. In addition, federal matching funds should not be denied to investigative agencies which are not part of the single state agency, such as Massachusetts' Bureau of Welfare Auditing or Ohio's State Auditors' Office.

Secondly, the increased FFP must be implemented and awarded to the states so as to assure the most effective use of funds and the achievement of the goals for which it was intended. An obvious model is the way in which the FFP for the Medicaid Management Information System (MMIS) was implemented. Each state wishing to take advantage of the increased matching available could apply for the funds through an "advanced planning document" to use the MMIS terminology.

Increased matching will not be of great benefit if the states merely use it as an increased subsidy for their existing activities. At the simplest level, DHEW could employ the "maintenance of effort concept" so that states are committed to their existing level of support for fraud/abuse control activities and the use of increased federal funding to expand the scope of the preexisting program.

Beyond maintenance of effort DHEW could be prepared to establish criteria for the certification of funds. Such criteria could include the types of staff included, nature and extent of training for staff members (particularly in the abuse area), the organization of responsibilities, plans for coordination with other agencies (especially with prosecutors), etc. Each state could submit a detailed plan of the objectives to be achieved with the additional funds, the methods for

achieving those objectives, the management approach to be used, and the information or reports which will be provided to DHEW as to the use of the funds and the objectives accomplished. This need not be a lengthy or difficult process that would delay fraud control efforts. But DHEW could act rapidly to establish the necessary regulations or guidelines if and when the legislative authority becomes available. DHEW must also provide prompt assistance to the states in developing the planning documents.

Training for personnel involved in Medicaid abuse control is particularly important, just as is increased availability of professional medical personnel in this area. The complexity of abuse issues requires extensive and continuing detailed training of abuse control personnel if the abuse control function is to be effectively carried out. A 90% match for training activities relating to program abuse should be given detailed consideration.

VII. OUTCOMES: SANCTIONS AND PENALTIES

Perhaps the most talked about but least understood part of the fraud control process is what is generically called "outcomes." What happens after a fraud or abuse case has not been prevented but has been detected and investigated. The Medicaid agency may attempt to secure any of a variety of outcomes in any given fraud case. The outcomes may include administrative suspension of the provider for a set period, recovery of funds, criminal prosecution, or any one of a number of other available options.

Which outcomes is to be sought in a given case depends on the nature of the case and the policy and philosophical outlook of the agency. Recovery of funds or recovery of funds with an administratively imposed penalty may be appropriate in some cases; for other cases spirited criminal prosecution may be appropriate. In any event, the Medicaid agency should recognize that the penalty must fit the crime if the system is to be successful in the long term. Furthermore, the agency should be aware that its investigations should be tailored to the desired outcome once the nature of the fraud and the most appropriate outcome have been agreed upon within the agency. A rigorous investigation sufficient to support criminal prosecution may not be warranted if the agency is planning to impose an administrative penalty for which the penalized provider is unlikely to appeal to the courts.

It should be emphasized that each Medicaid agency should include in its fraud control process a variety of potential outcomes or penalties. Prosecution is only one possible outcome. In general, it is the most expensive to achieve and is only likely to have a successful result in a limited number of cases. The goal of an effective fraud control program should not be prosecution per se. We believe that the options that follow provide a balanced program of which prosecution is only a part.

1. Program Administrative Procedures, Sanctions and Coordination

As discussed in the introduction of this paper, a fraud and abuse control program will only be as strong as the administrative procedures and regulations on which it is founded. When a provider enters the program, the provider agreement and regulations to which it relates must clearly specify the standards expected by the program and the mechanisms and penalties available to the Medicaid agency to protect the program and its clients from fraudulent providers.

It is essential that the regulations of the Medicaid agency in each state include an administrative process for dealing with "problem" providers. Reasons for the need for this administrative process include:

— Of the large number of "problem cases, very few will have the elements and supporting evidence of willful intent to defraud which is necessary to justify criminal prosecution. The vast majority of cases must be handled in some other administrative manner, which corresponds with the nature of the problem encountered.

— Criminal prosecution is extremely costly. If administrative mechanisms are availabe only a few of the many problem cases each year can be addressed because of limitations in resources and in the availability of prosecutors to handle the cases.

— The Medicaid agency should be able to settle cases at the lowest level of cost to the agency through administrative mechanizms, when appropriate.

— Since the probability for 100% recovery of illegitimately obtained funds is very small, the program should be able to administratively withhold some payments to a provider as soon as clear evidence of a problem exists and long before a formal outcome process is begun.

— Administrative procedures should give the agency the flexibility necessary to respond immediately to providers engaging in suspected fraud. Fraud is not deterred if persons considering committing fraud know that it will be months before the agency or prosecutors can take any effective action against them.

The following paragraphs provide more detail concerning the nature of the suggested administrative procedures and penalties for dealing with fraud.

A. Suspension of Payments

Suspension is a term which is used to mean various things in various contexts. It is often misunderstood. For purposes of Medicaid fraud and abuse control it most often has two meanings:

— Suspension as in "from participation in the program" usually for a limited period of time as a form of penalty; and

— Suspension of payment as in "suspending paying some or all of a provider's claims" until a problem has been clarified and rectified.

Both are of value. Suspension from the program is discussed later. Suspension of payments is of particular interest for two reasons. First, the administrative suspension of payment of some or all claims provides a strong incentive for the provider involved to reach a settlement with the Medicaid agency. In general, state agencies have few options available to them in fraud cases. Some fraudulent providers know this fact and therefore prolong negotiations while continuing their aberrant practice. Suspension of payment (if the option is available) is easy and demonstrates the policy of the agency to deal with fraud abuse. Secondly, suspension decreases the necessity for recovery. The probability of recovering all funds mispaid to a provider is very small for a variety of reasons. In fact the likelihood of recovering even a sizable proportion is small in many states. In addition, recovery efforts are expensive. Suspension of payments provides the state agency a needed mechanism for reducing the amount of funds misspent as soon as supportable allegations exist.

Some states currently suspend payment to providers in appropriate cases. Some of these states, however, believe such suspension is of doubtful legality. Other states have not implemented payments suspension for the same reason. Federal regulations do not deal with the issue. Regulations allowing or requiring suspension of payment in appropriate cases is one of the most important options which DHEW can implement for Medicaid provider fraud.

B. Administrative Money Penalties

Another sanction which is useful in some circumstances is imposition by the Medicaid agency of money penalties or administrative fines on providers who abuse or defraud the system. For example, a state might seek to recover not only funds obtained fraudulently but also a penalty of an additional 25% of the fraudulent payments, as in the policy of the State of Washington. Or a state might seek interest on the fraudulent payments during the time the money was held by the provider. Use of a sanction of this type, of course, must be coupled with an effective mechanism for suspension of all or part of current payments to a provider until recovery (including penalty) is made. It is much more efficient for a state to gain recovery through a reduction of current or future payments to a provider than to try to gain payment directly from the provider in question. In any event, collection of a money penalty or interest in addition to wrongfully paid amounts serves as a disincentive to fraud or abuse.

C. Suspension from Participation and Termination of Providers

Another administrative option for dealing with cases of provider fraud is suspension of the provider from participation in the program for a set period or complete termination of the provider. State plans should include clear provisions for suspending or terminating providers in appropriate cases. These provisions should be used only as a final administrative step, before prosecution, however, since suspension or termination may in effect penalize recipients as much if not more than providers in some circumstances. These sanctions are appropriate only if other methods cannot be successfully used for a given provider or if the health of recipients is endangered by the case rendered by a provider. Except in these circumstances, suspension of payments, imposition of administrative money penalties, or similar sanctions are probably more appropriate.

D. Hearings Procedures

The imposition of administrative penalties as discussed above requires that an administrative appeals procedure for providers exist. Federal regulations, similar to the Fair hearings procedures in the AFDC program, can be promulgated to provide a formal hearing procedure for providers who seek to appeal agency administrative decisions. Some states currently use such procedures as they are provided for in state administrative procedures acts. Federal regulations should be patterned after existing procedures in these states. Massachusetts is a good example. Such procedures usually call for conducting a formal hearing before the Medicaid agency head or his designee use formal procedures such as swearing witnesses, and following rules of evidence. Provisions are also made for representation of the parties by counsel.

E. Interstate Information Exchange on Provider Status

In those cases where termination from the program is carried out by a state, terminated providers may leave the state and begin practice in another state, again participating in the Medicaid program. The Federal government should consider establishing an information exchange mechanism to encourage and facilitate sharing of information concerning suspended and terminated providers. Currently there is no formal mechanism through which a state can check whether or not a particular new provider has been involved with questionable activities in another state's Medicaid program. Criteria

for "problem providers" in such a system would have to be clearly defined to protect providers' rights, but at least, medicaid fraud convictions and termination from the program are appropriate for reporting. This information exchange would provide a state the knowledge that a provider is seriously "error prone" and would allow that state to monitor the providers participation from the beginning. This would not harm the provider in any way, but would protect the program from substantial losses which might occur is aberrant practices went undetected for any length of time.

F. Coordination with the Medicare Program

As a final administrative matter, coordination with Medicare is essential. Although the nature of a Federal program in relation to a Federal state program like Medicaid presents some legal and administrative problems, the lack of coordination in the past has hindered effective fraud control. Since most providers participate in both programs, the coordination of detection information in particular is valuable even if joint investigations are not conducted. Currently coordination often comes too late in the fraud control process of each case. Providers often voluntarily drop out of Medicare before they are formally terminated for fraud or abuse. Thus Medicaid does not receive notice of Medicare termination and cannot take action. Coordination of fraud control efforts earlier in each case would be more beneficial to the Medicaid program and would allow effective administrative action.

At this early stage of the DHEW reorganization it is not possible to tell to what extent the consolidation of the two programs at the Federal level will in fact effect useful coordination. It is clear that careful study of the issues at the operational level must be made if progress is to be made in this area.

Administrative Sanctions & Procedures - Summary

To summarize, each state must have a fully developed process of administrative sanctions. Such a process should include not only the sanctions discussed above, but also such other elements as warning or cease and desist orders for minor infractions, and informal conferences with providers. Referral for prosecution should also be available if other sanctions do not achieve the desired goal.

It should be stressed that there is not necessarily logical progression through the various sanctions in any given case. A case which warrants prosecution may not go through any of the other steps since the agency might not want to show its intent over evidence before prosecution. But, most cases can be handled through warning letters and informal conferences if suspension of payments of claims is available to the program as an incentive for the provider to cooperate. Formal hearing and appeals to the courts by providers establishes a mechanism for ensuring that Medicaid agencies do not use the suspension or other administrative authority arbitrarily.

Suspension of payments authority coupled with clear authority to suspend or terminate participation is so important that Federal regulations might require that state plans include provisions providing these sanctions. We believe that this is one of the single most important recommendations in this paper. Implementation should have a dramatic impact on the ability of states to effectively counteract fraud.

2. Recovery

The most significant action which can be taken with respect to recovery is regulatory authority to suspend payment and thus prevent or reduce the amount which is misspent or which could be involved in a recovery action. Recovery is a costly function to conduct since it requires an agency to spend money to recover funds it misspent in the first place. Secondly, recovery is inefficient because it is necessary in some states to review individual claims and supporting documentation on a claim by claim basis to determine the amount to be recovered. This is not only very expensive but also means that it is unlikely that every misspent dollar will be identified. Thus

the situation facing the agency seeking recovery is that it must spend money to identify less than the total misspent funds of which it is likely to recover only a percentage. Furthermore, the provider involved has had use of such funds without paying an interest for some length of time. Furthermore, repayment is not really a penalty since the provider is only repaying the government's funds, not making an additional payment.

Given the inefficiencies of recovery, the following options are suggested.

— Sampling techniques can be used to estimate the amount of money owed by provider in order to save the cost of a full audit. This method is excellent for use as the basis of discussions with providers in which the agency seeks their agreement on amount of repayment. North Carolina officials, for example, said that the threat of a full scale on-site audit, led most providers to agree to the projected amount rather than undergo any embarrassment in his community caused by the presence of auditors.

— Civil recovery mechanisms are currently largely unused. DHEW should encourage states to explore using the civil recovery mechanism, perhaps in demonstration projects. It is important to remember that criminal prosecution rarely results in the repayment of a high percentage of funds and so for some cases civil recovery may be more desirable. Also in many states, in which recovery is handled by the state attorney general rather than at the county level, it would be simpler for the state Medicaid agency to use the civil recovery process than deal with each county prosecutor on criminal cases.

— Federal regulations could provide an incentive to states to recover by allowing the state to retain a percentage of the Federal funds involved in the recovery. Furthermore, the incentive could be more specific by requiring that recovered funds be applied to the Medicaid program and not returned to the state general fund.

— States should emphasize recovery with identifiable recovery units. Currently recovery is handled in a wide variety of ways and is not necessarily a clear priority. Recovery is not effective if funds are not actually collected. On this point, some states recover by subtracting payments on a schedule from future billings from the provider. This is likely to result in more effective recovery, but it reduces the extent to which recovery serves as a penalty, if this is the state's intent. Providers having past

excesses recovered from current claims should be monitored closely to ensure that they are not artifically increasing their billings to cover the amount to be recovered.

— Federal and State statutes should be amended to provide repayment with interest of fraudulently gained amounts as a non-suspendable part of any penalty for conviction. This repayment should not be in lieu of fines and jail sentences in appropriate cases.

3. Referral and Prosecution

Only a small proportion of aberrant practices detected will be suitable for or warrant criminal fraud prosecution. However, the Federal government and state agencies must have the capability to handle such cases.

There appear to be three major problems currently associated with achieving successful prosecution:

— inadequate availability of skilled investigators to put together the case and lack of coordination with Federal investigatory agencies;

— lack of resources and knowledge in the part of prosecutors and units to handle medicaid provider uses;

— weakness of current Federal penalties.

A. Investigative Support

The issue of the availability of skilled investigators has been addressed in the investigation section of this report. DHEW has recently taken steps to gain better coordination with Federal investigating agencies; DHEW could continue to provide leadership in this area and operationalize coordination with the FBI and IRS in particular.

A number of states have discovered fraud schemes which have involved interstate commerce. A laboratory operating in several states and defrauding the Medicaid programs in each is an example of such a case which was discovered by Michigan officials. In this case the FBI was brought in. States must have available to them mechanisms for accessing assistance from the FBI and other Federal agencies when a scheme of this type is discovered. Violation of Federal income tax laws are likely to be involved in almost all kickback schemes and factoring. Currently, IRS seems interested only once state Medicaid investigators have completed their investigation. It would appear that IRS should be involved earlier in these investigations rather than waiting for Medicaid to provide it a completed case.

In some of these cases it is likely that Federal statutes not related to Medicaid would provide greater penalties and could be used more effectively than existing state medicaid fraud statutes.

B. Prosecution Support

Prosecutors face two main problems with respect to Medicaid provider fraud cases: (1) such cases are time consuming and expensive to prosecute and (2) they involve complicated medical and financial issues. Thus prosecutors are often reluctant to prosecute these cases, particularly since Medicaid fraud is a misdemeanor under Federal law.

The first option in this area is to provide Federal financial support to state and local prosecution agencies, similar to the precedent which exists in the Title IV-D Child Support Enforcement program. Such financial support would make the cases more attractive. Given the backlog of cases and current demands on prosecution agencies it is unlikely the white collar crime cases will receive substantially more priority with prosecutors nationwide until more resources are available to prosecution agencies.

Secondly, DHEW must be able to assist prosecutors so that they can be readily familiar with the complex issues in such cases. The National District Attorney's Association, as part of its Economic Crime project funded by the Law Enforcement Assistance Administration, has developed substantial materials to assist prosecutors in Medicaid fraud cases and has a working relationship with the National Welfare Fraud Association.

DHEW should work with these or other organizations of this type to provide the informational support prosecutors require to feel comfortable handling these new types of cases. In our study we found a major problem was that prosecutors were unsure how best to deal with Medicaid cases. Prosecutors seem interested in the problem and will deal with it if resources and information are available.

Despite all efforts at gaining their cooperation, some prosecutors may still be reluctant to actively prosecute Medicaid fraud or abuse cases. In such circumstances the option of allowing DHEW or the State Agencies to prosecute the cases themselves becomes highly attractive. The Medicaid agency in a high volume state might find it desirable to employ an attorney simply to prosecute fraud and abuse cases. The fact that such an attorney

would gain great familiarity with the program and with the issues in fraud and abuse would likely make him more effective in gaining convictions than a non-agency prosecutor who only rarely handles such cases. Thus not only would appropriate cases be more readily prosecuted, but the efficiency of the prosecution would also likely increase. Similar independent prosecution authority for DHEW has also been proposed to Congress. While granting DHEW authority to prosecute major cases in which States have not acted is an important step, we believe that granting state Medicaid agencies independent prosecution authority is a more important step. Obviously, granting such authority is a matter for state lesiglatures. The federal regulations could be amended, however, to make the granting of such authority quite attractive to the states.

C. Statutory Support

Finally, medicaid fraud under Section 1909 of the Social Security Act is a misdeamor. This limits the utility of attempting to involve Federal authorities and prosecuting in Federal court. The current proposal to amend Section 1909 to make medicaid provider fraud a felony would make prosecution under Federal law more attractive. Such a legislative amendment might not have a major impact since the majority of prosecutable cases will likely continue to be prosecuted under state statutes. However, it will provide additional flexibility in the selection of outcomes particularly in those few cases that warrant action in the Federal courts. States should also give attention to tightening and strengthening their statutes.

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